INDICATIONS OF INSECURITY AMONG PSYCHIATRIC PATIENTS AND THE RELATIONSHIP OF THESE INDICATIONS TO PATIENT PREFERENCES IN NURSING CARE

by

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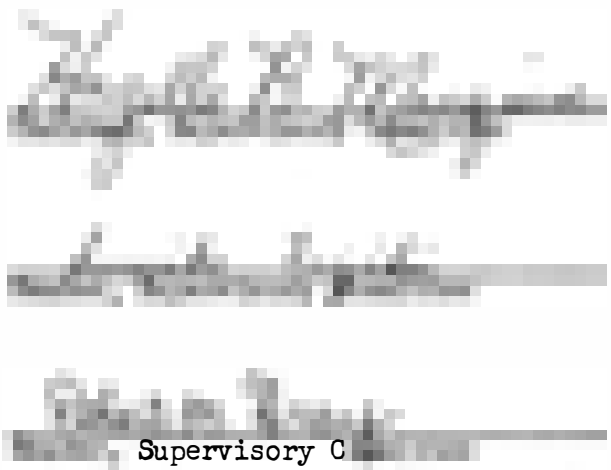

Supervisory C

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CHAPTER I

INTRODUCTION TO THE PROBLEM

This research was conducted in order to study the relationship between psychiatric patients' feelings of insecurity and nursing care that might be given to promote feelings of security. It is generally believed that most mentally ill patients feel insecure because some basic needs have not been met in the past and are not being met in the present in an adequate manner.

According to Maslow, needs can be arranged in a hierarchy moving from those most essential for maintaining physiological functions of life to those representing higher developmental levels of the individual such as self-esteem. Maslow lists five levels of needs; the first level is that of the physiological requirements, the second level consists of needs related to safety, the third level consists of the need for belongingness and love, the fourth level includes self-respect and self-esteem and the fifth level is a person's need for self-realization.[1]

Maslow states that if a person has the first three levels of needs met during his early years of development, this will provide the usual basis for adult security. Frustration of these basic needs generally gives rise to adult insecurity.[2]

As long as the person has basic needs that have not been met, he will be unable to move to a higher level of mental health and all his energies will be directed toward having the lacking needs satisfied. This is not a simple matter of identifying the need and having it fulfilled easily. According to Maslow:

> Once character structure has been formed, it becomes relatively independent of its origins and it may thus come about that the insecure adult remains insecure even when offered safety, belongingness, and love, though the already secure person can retain his security in the midst of a threatening, isolating, and rejecting environment.[3]

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[1] A. H. Maslow, "Higher and Lower Needs," Journal of [redacted] 25:433-436, 1948.

[2] A. H. Maslow, E. Brish, I. Honigmann, F. McGrath, A. Plason, and M. Stein, Manual for the [redacted] (Palo Alto, California, [redacted] Psychologists Press Inc., [redacted] p. 2.

[3] Ibid.

Since experiences of not having basic needs satisfied creates or increases feelings of insecurity and the insecure person tends to remain insecure until his basic needs are met satisfactorily, this research is an approach to the problem through studying how a person's reported insecurity is related to his preference for nursing care that is directed toward the satisfaction of these basic needs.

I. PROBLEM

Statement of the Problem: The purpose of this study was to find if preferences for certain kinds of nursing care as reported by a group of psychiatric patients, classified as insecure on the basis of the Maslow Security-Insecurity Test, would differ from preferences reported by a comparable group of patients indicated as more secure.

II. ASSUMPTIONS

Assumptions Leading to the Hypothesis: The following assumptions were made:

1. A person's score on the Security-Insecurity Test is an indication of that person's mental health.[4]

2. Different patients have different levels of security, and security is measurable so that patients can be divided into high and low security groups.

3. The patients have feelings about how they would like to be cared for in the hospital and they will be able to make some kind of report on their feelings.

III. HYPOTHESIS

The Null Hypothesis Formulated Was That: There will be no significant difference in reported preferences for certain kinds of nursing care between a group of psychiatric patients indicating a high score of insecurity and a comparable group of psychiatric patients whose scores rated them as more secure.

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[4]A. H. Maslow, Elisa Hirsh, Marcella Stein, and Irma Honigmann, "A Clinically Derived Test for Measuring Psychological Security-Insecurity," The Journal of General Psychology, 33:37, 1945.

Security is used in this study as it is defined by Maslow. In that context, security ". . .is one of the most important determinants of mental health (almost to the point of being synonymous with it.)"

IV. JUSTIFICATION OF THE PROBLEM

Mentally ill patients, in search of security may regress to a state where they require having basic needs met in a more dependent manner. Nurses are prepared to give patients care that is geared toward meeting these basic needs, such as feeding, bathing, or providing safety. One vital factor is often lacking, the understanding of how the patient feels about receiving this kind of care and what conditions are most favorable or even necessary to enable the patient to accept the care that will help satisfy these needs.

Schwartz and Schockley indicate that:

> Whatever a nurse is doing with the patient, bathing him, feeding him, giving him medication, playing games with him or sitting and talking with him, she is maintaining a relationship with him. We need to know more about these nurse-patient interactions and to understand their effects on patients.[5]

Information obtained through a participant observer on a psychiatric unit in a private mental hospital revealed one factor that may be preventing an understanding of these interactions:

> Both patients and staff structured their actions in accordance with a set of values and beliefs, but because the values and beliefs of each group were only incompletely known or understood by the other, the two groups viewed one another in terms of stereotypes which impeded an accurate evaluation of social reality.[6]

In recent years the nurse has become increasingly aware of the importance of the human qualities she brings into the situation and the value of the interaction which occurs between the nurse and the patient. It now becomes essential that more information be obtained about how patients feel concerning the nursing care they are receiving, and why they feel this way.[7]

Whether patients are, or are not, able to identify their own

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[5]M. S. Schwartz, E. L. Shockley, The Nurse and the Mental Patient. (New York: Russell Sage Foundation), p. 16, 1956.

[6]William Caudill, Fredrick Redlick, Helen Gilmore, and Eugene Brody, "Social Structure and Interpersonal Processes On a Psychiatric Ward," American Journal of Orthopsychiatry, 22:323, April, 1952.

[7]GAP Report No. 33, Therapeutic Use of the Self, A Concept for Teaching Patient Care. (Group for the Advancement of Psychiatry, 3617 W. Sixth Ave., Topeka, Kansas), June, 1955.

feelings, or are afraid to state their feelings, this study is still an essential first step. The patients' feeling about care received is part of the nurse-patient relationship and greatly influences its outcome.

This study, as an exploratory study, should give some direction for future research in this area. It should offer a basis for the planning of nursing care that will better contribute to the patients' satisfaction, security and improved mental health.

V. DEFINITION OF TERMS

S-I Test: The Security-Insecurity Inventory developed by Maslow and others.

Insecure Patients: Those patients scoring in the third and fourth quartiles of the range of scores obtained from the administration of the S-I Inventory. As defined by Maslow, one who is insecure has feelings of:

> being unloved, hated and despised; he feels isolated, ostracised, unique, jealous, hostile, discontented, and pessimistic; he is full of tension, guilt, shame and inferiority feelings. The insecure person perceives others as being dangerous, bad, evil, and he may have suicidal or psychotic tendencies.[8]

Secure Patients: Those patients scoring in the first and second quartiles of the range of scores obtained from the administration of the S-I Inventory. As defined by Maslow, one who is secure has feelings of:

> being loved, of belonging, of optimism, calmness, self-acceptance, and has social interest. There is a lack of hostility, jealousy and neurotic or psychotic tendencies.[9]

Kinds of Nursing Care: Specific nurse-patient interactions were selected to make items for a questionnaire.[10] In this study the nursing

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[8]A. H. Maslow, Elisa Hirsh, Marcella Stein, and Irma Honigmann, op. cit., pp. 21-22. See Appendix A for the complete table containing the definition of security and insecurity, as these are defined by Maslow.

[9]A. H. Maslow, Elisa Hirsh, Marcella Stein, and Irma Honigmann, "A Clinically Derived Test for Measuring Psychological Security-Insecurity," The Journal of General Psychology, 33:21-22, 1945.

[10]See Appendix B for Nursing Care Preference Test. See chapter three for details about its construction.

care items are limited to those kinds of care planned for meeting the first two levels of needs as Maslow lists them in his hierarchy of needs. These are the need for safety and the basic physiological needs.

Preference: In this study, patient preference was the person's reported feelings concerning whether he would or would not like a certain kind of nursing care.

Dependent Care: The kind of nursing care that suggests that a person is controlled, supported, or aided by others.

Independent Care: The kind of nursing care, that if allowed, would leave the person relatively free from the support or control of others.

V. LIMITATIONS

Generalizations from this study should be considered in the light of certain limitations. These are that:

1. The sample included a limited age range, was small in number, and was drawn from one state hospital.

2. The nursing care preferences were collected by a mimeographed questionnaire that gave the patients the opportunity to report a "Yes" or "No" preference for nursing care statements depicting selected types of care.

CHAPTER II

REVIEW OF LITERATURE

The review of literature had been focused on current information about (1) the validity, reliability and use of the S-I Inventory; (2) reports of research on patients' security and patients' reported feelings and preferences toward the nursing care they receive; (3) and the kind of nursing care usually given in psychiatric hospitals, and the kind of nursing care advocated in textbooks used for teaching basic psychiatric nursing. The review has been limited to that nursing care specified for meeting the kinds of needs listed in Maslow's first two levels of needs.

The literature is reviewed in the order indicated above.

I. SECURITY-INSECURITY INVENTORY

Development of test. The S-I Inventory is based on observations made by Maslow and his associates during years of experience in a clinical setting that treated young people of college age who had emotional problems. Maslow and his associates observed characteristics of clinically classified secure and insecure students and kept records of their reported feelings. These reports were eventually formulated into statements that were used as the basis of the present S-I Test. These statements were administered many times and had various revisions and statistical analyses done to determine their validity and reliability.[1]

Validity and Reliability. Nelson G. Hanawalt, Professor of Psychology, Douglass College, Rutgers University, gives a reserved report on the S-I Test, "The reliability is satisfactory, and the validity is about as good as can be expected."[2] Harold Webster, associate research psychologist, University of California, gives a more positive report,

> . . . it may be said immediately that it is doubtful that there are other personality tests the authors of which have exercised such great care to insure item validity. The test can be recommended without reservation as a valid measure of security-insecurity as the trait is described by the authors.[3]

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[1]A. H. Maslow, E. Brish, I. Honigmann, F. McGrath, A. Plason, M. Stein, Manual for the Security-Insecurity Inventory, (Palo Alto California, Consulting Psychologists Press Inc., 1952).

[2]Oscar Krisin Buros (ed.), The Fifth Mental Measurements Yearbook. (Hiland Park, New Jersey: The Gryphon Press, 1959) p. 191.

[3]Ibid. p. 192.

Basic Concept on Which Test Is Based. As Maslow views it, security is more than just a single entity. It is a global concept or syndrome.

> That is, it is a structured organized complex of apparently diverse specificities (behaviors, thoughts, impulses to action, perception, etc.) which however when studied carefully and validly are found to have a common unity that may be phrased variously as a similar dynamic meaning, expression, 'flavor,' function or purpose.[4]

In other words a person's sense of security would find expression in his behavior, feelings and outlook on life. Maslow divides the diverse specificities into matched subsyndromes (See Appendix A). Fourteen of these are representative of the inner feelings of the insecure person, and fourteen contrasting feelings are representative of the secure person. In the test each syndrome has approximately the same number of questions concerning it, of which one-half if answered "Yes", represent a secure response, and one-half if answered "Yes", represent an insecure response.

Maslow reports that security, as he defines it is "one of the most important determinents of mental health."[5] The sense of insecurity first occurs in the very young child and has the effect of causing that person to develop a continued longing for security. From Maslow's experience, those people lacking security had an "almost continued action toward regaining this individually defined security."[6]

Studies Conducted Using the S-I Inventory. In spite of its apparent careful construction and purposed vital mental health aspect, there are only a few reported studies where the S-I Inventory has been used. Sweetland and Shepler noted this and wrote a short article reporting, "We have used the test clinically and experimentally with very satisfactory results. A review of the literature however, indicates that few clinicians are using this test."[7] They reported using unweighted scoring norms with success and gave the mean and standard deviation of T scores to be used if a person desired to use it as a basis for comparisons.

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[4]A. H. Maslow, Motivation and Personality. (New York: Harper Brothers Publisher, 1954) p. 32.

[5]A. H. Maslow, Elisa Hirsh, Marcella Stein, Irma Honingmann, "A Clinically Derived Test for Measuring Psychological Security-Insecurity." The Journal of General Psychology, 33:37, July, 1945.

[6]A. H. Maslow, "The Dynamics of Psychological Security-Insecurity." Character and Personality, 10:336, June 1942.

[7]Anders Sweetland, and Bernard Shepler. "Unweighted Scoring Norms for the Security-Insecurity Test." Journal of General Psychology. 49:309, Oct. 1953.

Harrison G. Gough worked with the S-I Test and developed an easier scoring system. In a study on 260 high school seniors he also demonstrated that the S-I Score "was not influenced by intelligence, academic performance, or socioeconomic status, but that it was related to a number of the scales on the Minnesota Multiphasic Personality Inventory."[8] Gough also developed a table of standard scores to facilitate and encourage the use and interpretation of the S-I Inventory.[9]

Bennett and Jordan found that in 109 college students "the insecure group was significantly more extrapunitive at the .05 level than the secure group."[10]

Morris did an exploratory study of some personality characteristics of gamblers. The difference between the nongamblers and the gamblers on the S-I Test did not reach statistical significance.[11]

Several other studies were conducted using the S-I Inventory. None of the studies were with mentally ill patients.

Summary. If the S-I Inventory is an indication of the mental health of the individual, it seems more use could be made of this test in other studies that would promote the understanding of how to help people who lack mental health.

III. PATIENT PREFERENCES FOR NURSING CARE

In those studies dealing with patient preferences for various types of nursing care, none were found that examined the relationship of patients' preferences for care with some measured feelings such as security-insecurity. No report of the use of the S-I Test in a psychiatric hospital was found.

In "The Patients Tell Their Story," by Helen Pearce, a survey was reported from a psychiatric hospital of nine hundred (900) patients. The survey was to be used as part of a staff development program and they had intended that only a sample of patients should answer the questionnaire on nursing care. However, 796 of the patients expressed the wish to participate. Results of the study showed that the patients welcomed the

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[8]Harrison Gough, "A Note on the Security-Insecurity Test," Journal of Social Psychology, 28:257-58, November 1948.

[9]Ibid. p. 259.

[10]Carson Bennett, Thomas Jordan, "Security-Insecurity and the Direction of Aggressive Responses to Frustration." Journal of Clinical Psychology, 14:-167, April 1958.

[11]Robert Morris, "An Exploratory Study of Some Personality Characteristics of Gamblers." Journal of Clinical Psychology, 13:191-193, April 1957.

opportunity to review and participate in the programs of care offered them.

> The most helpful aspect of nursing service to these patients was supportive emotional care. They valued physical care, particularly environmental freedom, responsibility, and comfort, as well as the specific medication and treatment prescribed. They wanted more help in learning to live with themselves and with others, and with the world outside the hospital. . .[12]

William Caudill's study used a participant observer on a psychiatric ward for neurotic patients. It was found that the care these patients, on a partly conscious basis, showed resistance to, focused upon aspects of the hospital routine which were unduly infantilizing.[13] Many times patients were noted to report that the nurses had treated them like children.

In their study Sewall, Gillin, and LeBar found that the patients expressed many genuine complaints about the ways in which their needs were not being met and suggested what they thought would be more useful procedures to them. None of the areas explored in this study coincided with the present study except that about preferences for work. The patients preferred to work if the work was genuine work and not made to pass time.[14]

Newcomb reports that when he returned to the mental hospital in 1956, after an extended absence, he found that environmental conditions had changed but that personalized patient-care had not progressed commensurately during this interval. When four to five attendants were responsible for forty to fifty patients, they met the patients' general needs in an impersonal manner. When each attendant was assigned to ten or twelve patients for whom he was specifically responsible, the care became personalized and the desirability of this was evidenced by the increased number of patients who improved.[15] It would seem that basic physical care is not sufficient without some emotional involvement.

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[12]Helen E. Pearce, "The Patients Tell Their Story." American Journal of Nursing, 61:97, No. 4, April 1961.

[13]William Caudill, Fredrick Redlick, Helen Gilmore, and Eugene Brody, "Social Structure and Interpersonal Processes on a Psychiatric Ward." American Journal of Orthopsychiatry, 22:323, April 1952.

[14]L. Sewall, John Gillin, Frank LeBar, "Through the Patients' Eyes: Hospital-Patient Attitudes." Mental Hygiene. 39:284-292, April 1955, p. 290.

[15]Ernest P. Newcomb, "Personalization of Patient Care in a Mental Hospital." Mental Hospitals. p. 37, June 1961.

Lucretia Benolken, in a master's thesis reported "Factors Identified by Selected Convalescent Psychiatric Patients as Helpful Toward Improvement." The results showed emotional support was ranked very high and various other care listed in general categories followed. The thesis did not include a discussion of exact types of nursing care.[16]

Summary: In recent years, with the growing awareness of the importance of interpersonal relationships in psychiatric patient care, it has become important to find out the patients' opinions concerning this care. This lag in knowledge about how the patient feels may be due to past beliefs of people concerning mentally ill patients. The patients were considered and treated as if they were incapable of knowing what they wanted or how they felt.

II. CARE OF PSYCHIATRIC PATIENTS

Psychiatric Hospital Care. Nursing care may vary with each patient according to the type and degree of his illness. However, in a hospital most of the patients' care is regulated by rules and routines. Patients who are able to follow these rules and routines do so, while others who are too ill to follow them usually receive varying degrees of assistance.

Stanton and Schwartz in their study, The Mental Hospital, found that:

> The question of whether or not a patient should be treated specially became a pressing one for physicians and nurses. . .the hospital administration tended to favor uniformity and efficiency in treatment, and, as a corallary to this was active in teaching that treating a patient as a special case was to be avoided.[17]

In several studies done on the psychiatric hospital's social structure (e.g. Greenblatt,[18] Stanton and Schwartz,[19] and Caudill[20]), it was

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[16]Lucretia S. Benolken, "Factors Identified by Selected Convalescent Psychiatric Patients as Helpful Toward Improvement." (Unpublished Master's Thesis, Catholic University of America, June 1958), pp. 132.

[17]Alfred H. Stanton, and Morris S. Schwartz, The Mental Hospital. (New York: Basic Books, Inc. 1954), p. 316.

[18]Milton Greenblatt, Daniel J. Levenson, Richard H. Williams, The Patient and the Mental Hospital. (Glenco, Illinois: The Free Press, 1957), pp. 649

[19]Stanton, and Schwartz, op. cit.

[20]William Caudill, The Psychiatric Hospital as a Small Society. (Cambridge-Harvard University Press, 1958), pp. 406. (total)

found that the patients exerted pressure on each other to conform to the role of a patient as they had defined the role. Patients would criticise another patient if that patient's behavior was considered different from what might be expected of a person under his given circumstances. Patients were also criticised if they received special treatment from the staff.

The factors mentioned above influence the type of care patients can receive in psychiatric hospitals. With both the personnel and patients exerting pressure toward conformity, the usual care patients receive is reported in the literature as indicated in the following paragraphs.

It was observed that the patients and personnel although face to face during most of the day still had guarded attitudes and placed the emphasis of nursing care on prevention of running away from the institution, suicide, and assaultive behavior.[21] There was interaction between the patients and personnel only on perscribed levels and in perscribed ways.

Stanton and Schwartz speak of one of the characteristic ways in which needs are met in the hospital, and that is the enforced dependence of the patient.

> The fact that sick patients often feel dependence of a pathologic type tends to obscure the fact that regardless of this patients are forced into a dependent position. Food is served; patients cannot prepare it. Clothing is locked away; patients must ask for it. Schedules are made out for them; they cannot plan their own day. What this means is that a patient who comes to the hospital for some relatively specific defect in caring for himself is placed in a situation where he is cared for-in the passive voice-in all important areas. Such a regimen has an "educational" effect when long continued. It is also confusing: "dependence" as a pathological trait is found where it does not exist.[22]

In a study done by Sewall, Gillin and LeBar, the existence of the above listed conditions in the hospital caused them to report that:

> . . .what he actually learns is conformity to routine, dependence on others for decisions, development of fixed performance and timetable habits, and reliance on resources that others make available. It would be difficult

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[21]Ernest P. Newcomb, "Personalization of Patient Care in a Mental Hospital." Mental Hospitals, p. 37, June 1961; and Olive M. Stone, "The Three Worlds of the Backward." Mental Hygiene, 45:18-27, Jan. 1961.

[22]Stanton, and Schwartz. op. cit., p. 54.

> to conjure up a more useless set of patterns for a man about to go back to the outside world.[23]

They felt that the treatment of the patient would be more beneficial if the hospital considered what experiences the patient needed to function well in society.

Stanton and Schwartz point out the difficulty of trying to achieve an individual patient centered ward climate. "There is much variability from person to person, from situation to situation, and on top of this, variability in the way in which any one individual conceives the situation."[24] For example, many patients will complain about having to use plastic eating utensils. However, if the patients are given metal eating utensils there will be one or two that complain bitterly because they realize the possibility of using these as instruments of self-injury and feel the hospital is not protecting them as it should. To change the policies of the hospital would probably satisfy some of the patients but would be quite detrimental to other patients. It is difficult to give individual care and for this reason hospital care is often geared to caring for the sickest possible patient.

Nursing Education. Textbooks on psychiatric nursing emphasize that the care given a psychiatric patient should be related to the needs the patient is displaying and his present level of functioning. Brown and Fowler in their textbook explain that different patients will need help in selecting their clothes, dressing, making simple decisions, carrying out personal hygiene measures such as bathing, keeping the hair nice, or shaving. They may need help in deciding what to eat, in some cases even requiring the nurse to spoon feed them. Patients may manifest problems in elimination by retaining both feces and urine.[25] Their habits in this respect should be closely observed by the nurse.

Protection is usually offered patients in several ways. In addition to protecting the patient from self-injury and self-mutilation or injury to others:

> The hospital environment should also protect him from indiscriminate confessions. . .and from any major decisions which are beyond his current level of responsibility, such as decisions about his finances.[26]

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[23]L. Sewall, John Gillin, Frank LeBar, "Through the Patients Eyes: Hospital-Patient Attitudes." Mental Hygiene, 39:284-292, April 1955, p. 290.

[24]Stanton, and Schwartz. op. cit., p. 54.

[25]Martha Montgomery Brown, Grace R. Fowler, Psychodynamic Nursing. 2nd ed. (Philadelphia: W.B. Saunders Company 1961) p. 182.

[26]Ibid. p. 285.

Render and Weiss noted many of the same nursing care problems as Brown and Fowler. This included the necessity of feeding the patient, of protecting him (as an infant), and the necessity of watching his habits of elimination. Concerning sleep, "this is considered an important universal therapeutic measure"[27] and it is a nursing responsibility to see that the patient gets the sleep without sedation.

Building faith or trust in the patient is viewed as very important by Render and Weiss, Peplau[28], and others.[29] They list several things that are considered as contributing factors to this faith. Among these were included the giving of special attention to a patient's grooming. The nurse should help the individual in hair grooming, giving manicures, providing the patient with individual bright colors, making certain the clothing has all the buttons attached, has no spots, the hose are without runs, and the dress is freshly pressed.

Render and Weiss also note that the patient cannot always be made to do just as the nurse wishes because, as an individual, he has feelings, can think, and can make decisions. He has will-power to try to enforce these decisions. Because these decisions may run counter to the prescribed treatment and care, one should be aware that:

> Nursing care does not necessarily mean pleasing the patient or doing what he wants done, it means providing what he needs but, at the same time, helping him learn to meet his own needs.[30]

Nurses may develop conflicting feelings about the type of care they should be giving the psychiatric patients. Schwartz and Shockley in their book, The Nurse and the Mental Patient, noted that:

> In relating to a patient who is withdrawn, slow-moving, (etc.), the nurse sometimes becomes concerned about treating him as a child. . .she may have to take the initiative in bathing, in feeding, (etc.), or in other ways caring for him as she would a very small child. She may fear that helping him in these ways is disrespectful to him and that her

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[27]Helena Render, and Olga Weiss, The Nurse-Patient Relationship in Psychiatry. (New York: McGraw-Hill Book Co., Inc. 1959) pp. 106-281.

[28]Hildegrad E. Peplau, Interpersonal Relations in Nursing. (New York: G.P. Putman's Son, 1952) pp. 309.

[29]Louis J. Karnosh, and Dorothy Mereness, Psychiatry for Nurses. 4th ed. (St. Louis: The C. V. Mosby Company, 1953). pp. 496. Ruth V. Matheney, and Mary Topalis, Psychiatric Nursing. (St. Louis: The C. V. Mosby Company, 1961). pp. 265. and Marion E. Kalkman, Introduction to Psychiatric Nursing. (New York: McGraw-Hill Book Company, Inc. 1950). pp. 324.

[30]Render and Weiss, op. cit., p. 106.

behavior may continue the patients' dependence on her and prevent him from developing emotionally.[31]

This conflict is important to note because the feelings a nurse often has about whether to give "dependent" care or not to give "dependent" care influences the patient's feelings about receiving it. Schwartz and Schockley express this well in the statement that "nursing education is only at the beginning of helping nurses in any systematic way to handle their feelings and behavior constructively for the benefit of patients and themselves."[32]

IV. SUMMARY

Much information is available describing seriously ill patients and what kinds of nursing care they received that helped them become well. Very little research has been conducted to explore in a systematic manner the relationship between types of nursing care given and the patient's responses to it.

Psychiatry and psychoanalysis have both been attacked because of their lack of scientific evidence to support their theories. Nurses will also be attacked unless they can in some systematic way, preferably with control groups, demonstrate to others the value of the care they are giving to patients. This study is an initial step in that direction. How does the person's mental health, as measured by the S-I Test, influence his reported preference toward types of nursing care he is usually offered?

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[31] Morris S. Schwartz, Emmy Lanning Shockley, The Nurse and the Mental Patient. (New York: Russell Sage Foundation, 1956). p. 256.

[32] Ibid. p. 10.

CHAPTER III

METHODS USED IN CONDUCTING THE RESEARCH

In this study the research was directed toward obtaining data about feelings of security or insecurity in patients and toward seeing if these feelings were related to preferences for kinds of nursing care.

I. SELECTION OF A TOOL FOR MEASURING PATIENTS' FEELINGS

The S-I Inventory was selected as the tool for measuring the patients' feelings because: (1) Security and insecurity as they are defined by Maslow seemed to be basic factors that would influence the patients' need for nursing care; (2) The tool was well constructed and had been tested for its validity and reliability; (3) The test was relatively easy to administer, read and understand. This was considered to be an important factor since the test was to be administered to mentally ill people. (4) It was not necessary for the person who administered the test to be highly trained or skilled. (5) The test had been recommended for use "in colleges, hospitals, and other institutions for singling out those cases most in need of closer psychological attention."[1] The test was constructed to be used with large groups of people.

II. NURSING CARE PREFERENCE QUESTIONNAIRE

Decisions Regarding Information to be Sought. The information sought was the patients' opinion of the type of nursing care he would prefer if he were given a choice in the matter. Since this was to be structured into a questionnaire the number and type of choices were naturally limited. It was decided that the nursing care statements should be representative of the kind of care that psychiatric patients may need and the kind of care that is often given in psychiatric hospitals.

The items of nursing care were constructed after consideration was given to their relationship to the basic needs identified by Maslow to the dependent or independent nature of nursing activities, and to theories of personality development. All of the items were statements of care that would meet basic needs of people. These needs were selected from the

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[1] A. H. Maslow, E. Brish, I. Honigmann, F. McGrath, A. Plason, M. Stein, Manual for the Security-Insecurity Inventory. (Palo Alto, California: Consulting Psychologists, Inc., 1952).

theories of Freud,[2] and Maslow.[3] Needs can be divided into as many subdivisions as a person may desire. The needs considered in this study were limited to the first two levels of Maslow's hierarchy. These are the physiological needs and the need for safety.

In meeting these basic needs various other, rather intangible needs, such as the need for respect, or love can be met by the same care. This factor is recognized. However, no attempts were made to measure these intangible factors.

The hospital meets the patients basic needs in the following areas: eating, sleeping, personal grooming, disciplining, safety, and elimination. The patient is offered protection from the environment including other patients, and protection from himself. He is given response of some kind. Finally the hospital assumes the responsibility for helping the patients make proper decisions or makes decisions for them. Attempts were made to include items that would have reference to nursing care in each of these areas.

Deciding What Type of Questionnaire Should be Used. Since this questionnaire was to elicit patient preferences for kinds of nursing care, it was decided that explicit questions would obtain the desired results. The questionnaire was constructed so as to be easily read, understood, and answered.

It was decided that the items in the questionnaire should be constructed so as to avoid any set pattern of responses. To offer a means of checking consistency of the patients' responses the items should be constructed so as to include statements requiring opposite responses for the same type of nursing care. The questionnaire should also give some range in the kinds of care for which the patients could state their preferences. The nursing care should apply equally to male and female patients and should avoid if possible cultural variables that would influence the patients' responses.

Construction of the Questionnaire. The items were constructed with consideration of how an infant or young child would require having a specific need met as opposed to how a well adult would require having the same need met. All items were developed in this manner. After the list of items had been formulated, they were given to five psychiatric nurses who were engaged in graduate studies in psychiatric nursing, to classify as to whether the item depicted care suited to a young child or if it were suited to an adult. These people found it difficult to classify the items in this manner because the circumstances surrounding the situation would influence whether the item could be classified as more

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[2]Sigmund Freud, A General Introduction to Psychoanalysis. (New York: Liveright Publishing Corporation, 1935). pp. 412.

[3]A. H. Maslow, Motivation and Personality. (New York: Harper and Brothers, 1954). pp. 411.

suitable for meeting the needs of an adult or more suitable for meeting the needs of a child.

In view of this report, it was decided that it would be desirable to state the items in a more explicit manner and use a more functional method of classifying them. A classification that would depict the dependent or independent quality of the person receiving the care was decided upon and "dependent" or "independent", as these words are defined in the definition of terms, was used.

Most of the dependent nursing care items had a corresponding independent nursing care item included in the test. Some of the nursing care items were written to show nursing care which expressed varying degrees of dependence; for example, the items referring to the patients attending occupational therapy were constructed in that manner. (Avoid telling me what to make in O.T.; Help me decide what to make in O.T.; and Tell me what to make in O.T.) A few items were used which by the nature of the respondent's choice for preference or non-preference would reflect a dependent or independent quality.

To help clarify the wording of the statement, each statement was evaluated for wording and clarity by a person not in psychiatric nursing. The content and reasoning behind each statement was reviewed by the head of the psychiatric nursing graduate program.

Further Checking of the Items for Classification. The items were arranged in random manner and sent to seven experts in psychiatric nursing. Each of these people had a master's degree in psychiatric nursing, and had varying degrees of experience. They were all currently employed in the field of psychiatric nursing as teachers in universities, or supervisors of special psychiatric units. Their educational background varied and they were employed in settings that varied from the Midwest to the Pacific Coast.

These experts categorized the statements as dependent or independent, as these are defined in the definition of terms. An "X" was used to indicate any statement they found difficult to classify as dependent or independent. (For the letter and specific instructions, see Appendix C and D.) The consultants were invited to make any comments concerning the questionnaire they might wish.

Briefly the comments received were that: (1) Because the nursing care takes place within a psychiatric setting, and the patients are under the control of the hospital, all of the statements have a dependent flavor. The statements marked "independent" were those indicating that the speaker seemed to have identified some possible independent action on his part and was suggesting that he carry out this action independently of another. (2) The experts showed some concern about the fact that sometimes the acceptance of dependent care would indicate a healthier individual than one who must always be independent. The complexity of the possible meanings of these statements is realized, but it is not within

the scope of this thesis to study the possible interpretations. The main objective as stated before is to find if there is a relationship between the nursing care preferred and the patients' degree of security.

Final Questionnaire Form. These statements were eliminated on which the seven authorities were not in agreement. Out of seventy-five statements sent to the consultants, fifty-one statements were included in the final questionnaire. Of these, thirty were classified as dependent statements and twenty-one were classified as independent statements. These statements were again arranged so that similar or contrasting questions were scattered throughout the final questionnaire, and there was not a set pattern of "Yes" or "No" responses. (See Appendix B).

III. SETTING FOR COLLECTION OF DATA

Arrangements for conducting the research were made with personnel of a psychiatric hospital in a neighboring state. The state population was predominantly rural, but the hospital, where the study was conducted, drew the majority of its patients from three neighboring cities that ranged in size from fourteen to twenty thousand in population. The hospital was staffed with fourteen registered nurses, six licensed practical nurses, and one hundred and thirty attendents, aids, and technicians, to care for the five hundred and eighty-three patients.

IV. SELECTION OF THE SAMPLE

The hospital personnel provided the names of all the patients between fifteen and thirty years of age. This age range was selected for testing because the S-I Test was recommended for use in high schools and for adults. Since it had been standardized on college students, it was decided not to vary too far from the age range found among college students. Also this age range, between fifteen and thirty, would result in a more homogeneous group as to diagnoses, eliminating senile conditions and some health conditions that might influence preferences for kinds of nursing care. Fifty-four patients of this age range were in residence at the hospital during the time the tests were administered. Of those tested four of the patients were too ill to respond coherently when a question was asked of them. Their tests were inadequately filled out and had to be discarded. Patients included in the final sample were fifty in number and came from ten different wards in the hospital.

Under six broad classifications such as schizophrenia, personality pattern disturbance, and chronic brain syndrome, these fifty patients had twenty-four different diagnoses. Over fifty percent of the patients were diagnosed as various types of schizophrenics, while a very few or sometimes only one was included under some of the other diagnoses.

Additional information gathered to help with the interpretation of the data. In addition to the personal data gathered on each patient, information concerning the routines, rules, regulations, and type of nursing care given on each ward was assembled to help in interpreting the patients' responses on the Nursing Care Preference Questionnaire.

V. COLLECTION OF THE DATA

The tests were administered to the patients in groups. The groups ranged in size from one or two persons to nine persons, depending on each patient's condition at the time of the testing. Each patient was assigned a number to match the Security-Insecurity Inventory and questionnaire with the right person. This number was on a master sheet with all the personal information.

Before the tests were administered the patients had been informed that the tests were being administered by a research person who was trying to help improve psychiatric nursing care. The staff reported that the patients seemed eager to participate.

It was stated to the patients to whom the test was administered that:

> The tests are to be given in two parts, one that you will receive now and another one which will be given to you later. Please be honest with your answers -- there is no right or wrong to any response you make. Please do not discuss the questions with others who will be taking the tests.

It was explained that the information was to be used in research to improve nursing care in psychiatric hospitals, that patients' names would not be used and that the information would be kept confidential.

The directions for each test were read by the research worker as it was given out. Any questions an individual asked were written down and all persons asking that question received the same answer.

The testing procedure went smoothly for most of the patients. Very few of them had questions. Some of the patients were concerned about the test and afraid it would affect their being released. No one was obviously hostile or refused to take the test.

VI. STATISTICAL PROCEDURES SELECTED

Chi square statistics were used to evaluate the significance of the relationship between the two groups of patients. Chi square (X^2) is used with qualitative data. It is based on the deviation of an observed

frequency of some event from the theoretical frequency of the same event.[4] It can be calculated quickly and has been found useful in social science research. The formula for chi square is: $X^2=\sum\frac{(fo-ft)^2}{ft}$. The values of chi square for the given number of degrees of freedom that are significant were obtained from Table F in Dornbusch's A Primer of Social Statistics, page 243.[5]

Chi square does not show the strength of the relationship between the two frequencies. It was decided to use phi coefficient to measure the strength of the relationship between any frequencies that were found to be significant by chi square.[6] The formula for phi coefficient is: $\phi=\sqrt{\frac{X^2}{N}}$

A phi coefficient of zero would occur only if chi square were zero. The strongest relationship would be indicated by 1. The phi coefficient does not indicate the direction of the relationship. This has to be determined by studying the chi square tables.

Other elementary statistics were used to find the mean and standard deviation of the Security-Insecurity Test. These were used primarily to see how this group of people compared with other groups who had taken the test.

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[4]Stanford M. Dornbusch, and Calvin F. Schmid. A Primer of Social Statistics. (New York: McGraw-Hill Book Company, Inc., 1955). p. 213.

[5]Ibid., p. 243.

[6]Because the values of chi square were not significant, it was not necessary to use the phi coefficient.

CHAPTER IV

ANALYSIS AND COMPARISONS OF THE DATA

The data were subjected to several different methods of analysis. In addition to calculating the mean, median, standard deviation, and the chi square test, percentages were used to facilitate examination of the data in the tables.

I. RESULTS OF THE S-I INVENTORY

On the S-I Test the patients' raw scores ranged from two to sixty-five. (The highest possible insecure score was seventy-five.) The frequency distribution of scores showed a slight skewing toward security. (See Figure 1.) The mean of all the scores was thirty-one. The standard deviation was fifteen and four tenths (15.4). Through his studies with the S-I Inventory, Maslow indicated thrity-one as the score at which, and above which, people were to be considered insecure. The standard deviation for these psychiatric patients was larger than the standard deviation reported in the S-I Manual for any of the other groups of people who had taken the test.[1]

The patients' S-I scores were ranked and divided at the fiftieth percentile. The score at the fiftieth percentile was thirty-one; the same score Maslow had indicated as the beginning of the insecure group. For the purposes of this study, those patients scoring in the upper fifty percent of the ranking were classified as having low security and those patients scoring below the fiftieth percentile of the ranked scores were classified as having high security.

II. FINDINGS OF THE NURSING CARE PREFERENCE TEST

The Nursing Care Preference Test had fifty-one items that could be scored as dependent or independent responses. If the patient did not indicate a preference for the independent care, this was marked as a dependent response. The scores on the Nursing Care Test indicating a preference for dependent care ranged from three to twenty-nine. The mean score was thirteen and sixty-one hundredths (13.61). There was a skewing toward preference for kinds of nursing care offering the individual independence. This number was used as the dividing point between those

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[1] A. H. Maslow, E. Brish, I. Honigmann, F. McGrath, A. Plason, and M. Stein, Manual for the Security-Insecurity Inventory. (Palo Alto, California, Consulting Psychologists Press, Inc., 1952).

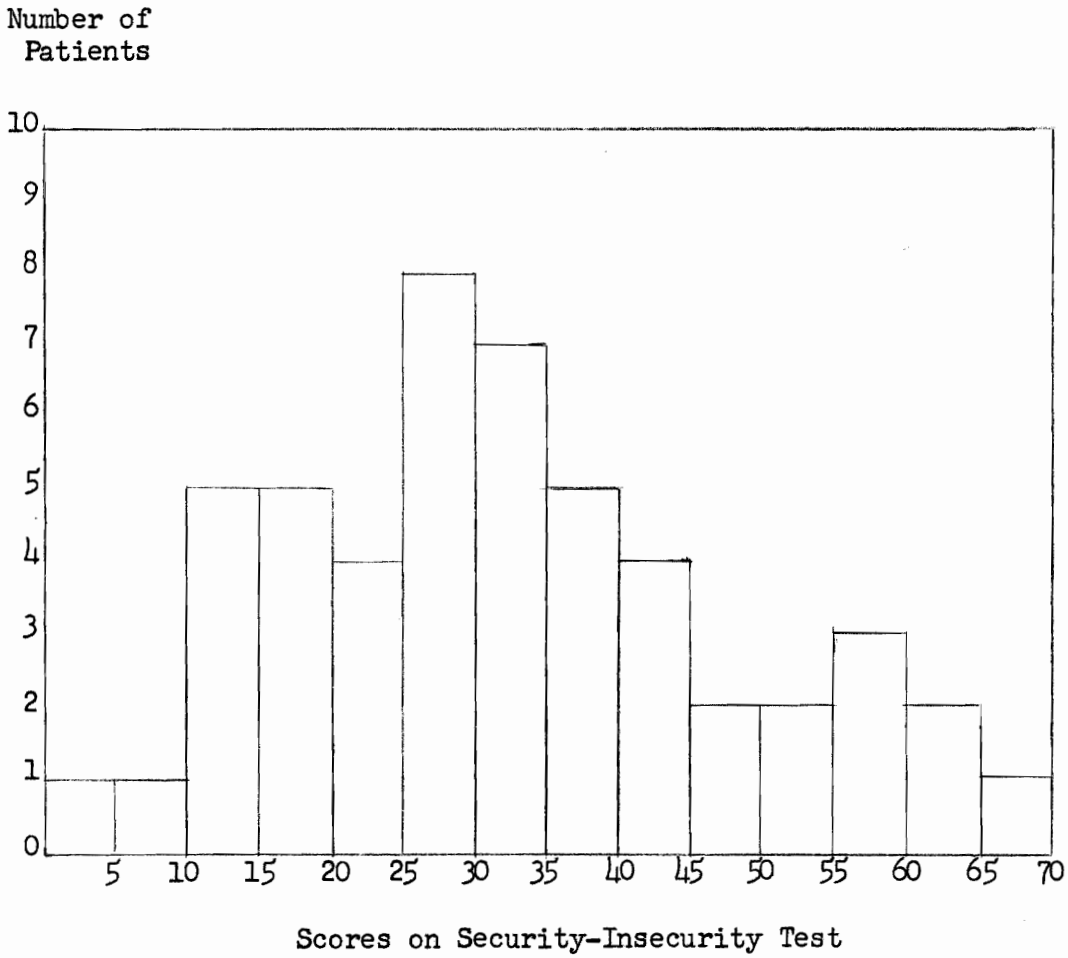

Figure 1

DISTRIBUTION OF SECURITY-INSECURITY SCORES FOR FIFTY PSYCHIATRIC PATIENTS

patients considered as having high scores on the Nursing Care Preference Test and those patients considered as having low scores on the Nursing Care Preference Test. (See Figure 2.)

The preferences reported for the Nursing Care Preference Test varied widely. It was the tendency for the persons answering the Nursing Care Test to indicate a preference for items that had been classified as independent. It is interesting to note, however, that only three of the twenty-one independent statements received a "Yes" response from everyone. The remaining eighteen independent items had one or more persons indicating "No" to that type of care.

None of the dependent statements received one hundred percent "Yes" responses although some fell into the eighty percent range. This indicated that most of the nursing care items discriminated to some degree the patients preferences for the different kinds of nursing care.

Only a small percentage of the patients indicated that they did not prefer the independent nursing care items. In contrast to this, when these patients were offered the same care in the dependent nursing care items, a higher percentage indicated a desire for this kind of care. As an illustration: all patients responded "Yes" to this statement, "When people are taking care of me, I wish they would give me the opportunity to clean up my own mess." To its dependent counterpart statement, "When people are taking care of me, I wish they would clean up my mess," thirty percent of the patients reported "Yes".

This trend occurred on all of the matched independent and dependent nursing care items. More patients would indicate that they preferred the dependent nursing care than would indicate that they did not prefer the more socially acceptable independent care.

III. RELATIONSHIPS BETWEEN THE SECURE AND INSECURE GROUPS IN THEIR PREFERENCES ON THE NURSING CARE PREFERENCE TEST

Chi Square. A two by two chi square table was used to indicate if there was a relationship between the secure and insecure group and those who scored high and those who scored low on the nursing care preference test. Chi square was found to be .32. With one degree of freedom, for the results to have been significant at the five percent level, the value should have been greater than 3.841.[2] Therefore, the null hypothesis that there would be no significant difference in reported preferences for nursing care between a group of psychiatric patients indicating a high score of insecurity and a comparable group of psychiatric patients whose

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[2]Sanford M. Dornbusch, Calvin F. Schmid. A Primer of Social Statistics. (New York: McGraw-Hill Book Co., Inc., 1955). p. 243.

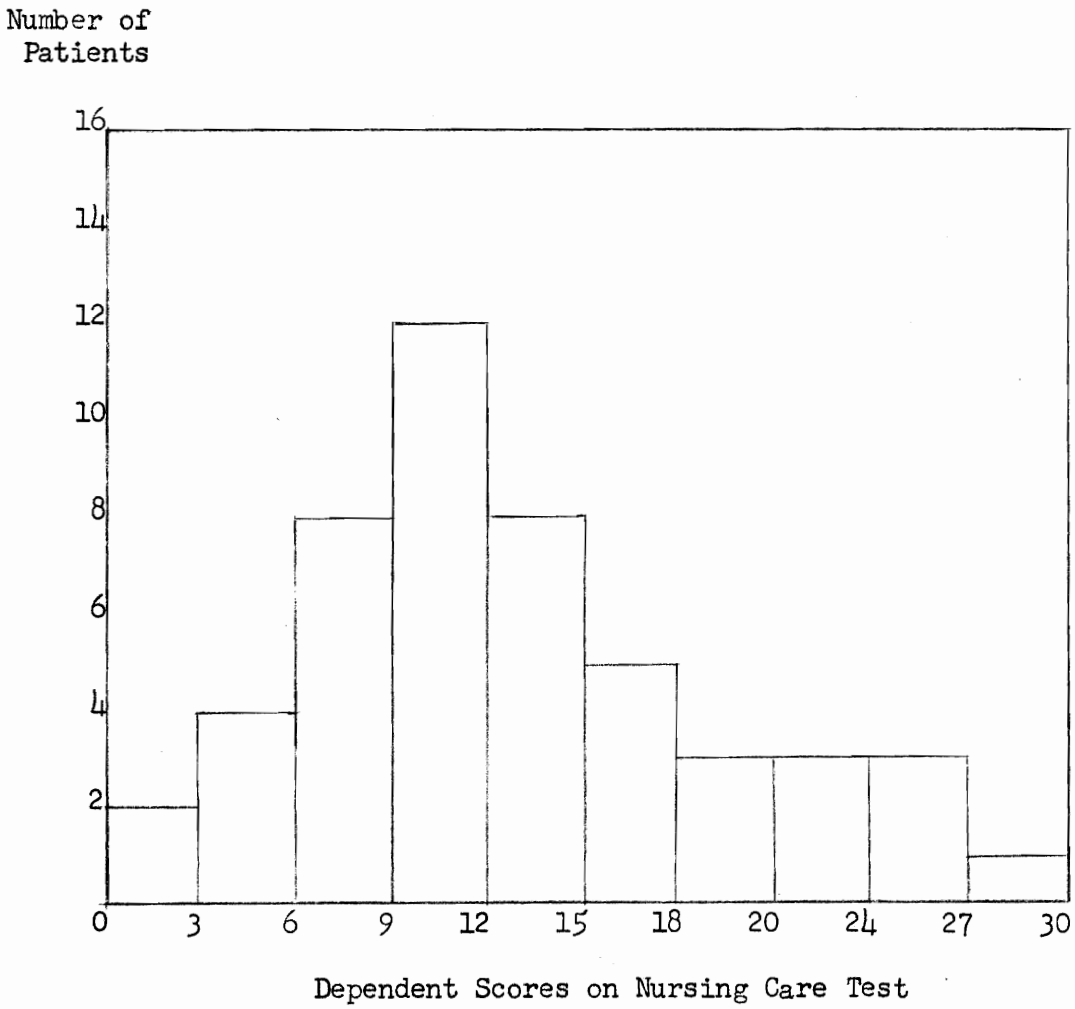

Figure 2

DISTRIBUTION OF DEPENDENT RESPONSES TO THE NURSING CARE STATEMENTS FOR FIFTY PSYCHIATRIC PATIENTS

scores rated them as more secure, was supported. In this study there was no significant difference in the reported preference for kinds of nursing care between a group of psychiatric patients indicating a high score on the S-I Inventory and a comparable group of patients indicating a low score.

Chi Square and Individual Nursing Care Items. The chi square two by two table was then used to determine if there was a significant difference between the secure and insecure groups in their preferences for each of the individual nursing care items in the questionnaire.[3] Out of the fifty-one items, only one showed enough difference between the groups to indicate a significant relationship on the chi square table.

The item that showed significance was the one stating, "When people are taking care of me, I wish they would make certain I get to bed on time." It was those patients, classified as more secure who indicated a preference for this type of nursing care. This one item showing a significant relationship out of the fifty-one items on the test cannot be accepted as a significant finding.[4] It should be noted, however, that this one item was in agreement with the predominent pattern revealed on examination of the proportion of responses in each group.

Although not statistically significant, several patterns or trends were discernable in the patients' reported preferences for individual dependent or independent nursing care items. On Table I the patients were divided into the secure and insecure groups. The number and percent of "Yes" responses reported by the two groups on the Nursing Care Preference Test was noted for each dependent and independent nursing care item. Frequencies for different patterns of responses were noted. One general pattern emerged.

First, as it can be noted on Table I, it was the secure group of patients who had the greater frequency of indicating "No" to the independent nursing care items. They tended not to show a preference for independence as it is indicated by these statements. Second, it was the secure group of patients that indicated "Yes" more frequently to the dependent nursing care items.

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[3]Frank Wilcoxon, Some Rapid Approximate Statistical Procedures. (New York 20, New York: Cyanamid Company, 30 Rockefeller Plaza, Revised July 1949). p. 7. When several treatments have been compared in an experiment, it is desirable to apply a statistical test which will indicate whether the treatment as a whole differ among themselves, before picking out pairs of treatments for the individual comparisons. If the treatments as a whole cannot be shown to differ, caution should be used in claiming individual differences between certain treatments.

[4]Ibid.

TABLE I

PATIENTS' REPORTED PREFERENCES FOR NURSING CARE STATEMENTS

Type*	Nursing Care Statements	Group**	"Yes" Responses To Statement	
	When people are taking care of me I wish they would:		Number	Percent
Ind.	Allow me to manage my own money.	I	25	100
		S	23	92
Dep.	Advise me on how to spend my money.	I	5	20
		S	6	24
Ind.	Avoid telling me what to make in O.T.	I	20	80
		S	18	72
Dep.	Help me decide what to make in O.T.	I	7	28
		S	10	40
Dep.	Tell me what to make in O.T.	I	1	4
		S	4	16
Dep.	Not give me any responsibility.	I	1	4
		S	4	16
Ind.	Let me assume job responsibility without others interference.	I	25	100
		S	24	96
Dep.	Prevent others from doing the job that was assigned to me.	I	19	76
		S	19	76
Ind.	Give me the opportunity to clean up my own mess.	I	25	100
		S	25	100
Dep.	Clean up my mess.	I	7	28
		S	8	32
Dep.	Keep sharp knives and instruments away from me.	I	14	56
		S	8	32
Dep.	Stay with me when I am using sharp knives and instruments.	I	9	36
		S	10	40
Ind.	Let me decide who can or cannot take my belongings.	I	22	88
		S	22	88

* Type Ind. Independent nursing care statement.
Dep. Dependent nursing care statement.

**Group S Secure Group.
I Insecure Group.

TABLE I (CONTINUED)

PATIENTS' REPORTED PREFERENCES FOR NURSING CARE STATEMENTS

Type*	Nursing Care Statements	Group**	"Yes" Responses To Statement	
	When people are taking care of me I wish they would:		Number	Percent
Dep.	Prevent patients from taking what belongs to me.	I	21	84
		S	23	92
Dep.	Defend me when others are angry with me.	I	11	44
		S	10	40
Ind.	Avoid interfering when someone else is angry with me.	I	19	76
		S	16	64
Dep.	Stop me from becoming angry.	I	11	44
		S	13	52
Dep.	Teach me not to become angry.	I	14	56
		S	18	72
Dep.	Ask about and show an interest in the things I am doing.	I	21	84
		S	22	88
Ind.	Allow me to plan my day's activities.	I	20	80
		S	21	84
Dep.	Put an arm around me when comforting me.	I	10	40
		S	12	48
Ind.	Provide warm covers and let me use them if I please.	I	24	96
		S	21	84
Dep.	Check during the night to see that I am covered and warm.	I	6	24
		S	6	24
Dep.	Make certain I get to bed on time.	I	2	8
		S	7	28
Ind.	Permit me to decide when I should go to bed.	I	25	100
		S	21	84
Ind.	Let me report when I am constipated.	I	22	88
		S	23	92
Dep.	Watch me so that I do not become constipated.	I	6	24
		S	7	28

*Type Ind. Independent nursing care statement.
Dep. Dependent nursing care statement.

**Group S Secure Group.
I Insecure Group.

TABLE I (CONTINUED)

PATIENTS' REPORTED PREFERENCES FOR NURSING CARE STATEMENTS

Type*	Nursing Care Statements	Group**	"Yes" Responses To Statement	
	When people are taking care of me I wish they would:		Number	Percent
Ind.	Not worry about how much I eat.	I	18	72
		S	18	72
Ind.	Leave my food alone and let me feed myself.	I	24	96
		S	24	96
Dep.	Cut up my food and help me eat.	I	3	12
		S	2	8
Dep.	Be concerned about keeping me properly dressed.	I	16	64
		S	11	44
Dep.	Be with me to help me dress.	I	3	12
		S	2	8
Dep.	Keep me in clean clothes.	I	20	80
		S	22	88
Ind.	Provide equipment so I can keep my clothes mended and ironed.	I	25	100
		S	24	96
Dep.	See that my clothes are mended, cleaned and ironed.	I	13	52
		S	10	40
Ind.	Let me take care of my own clothes.	I	24	96
		S	24	96
Dep.	Keep my clothes in neat order.	I	11	44
		S	11	44
Dep.	Select the things that I should wear.	I	2	8
		S	2	8
Ind.	Allow me to choose what I want to wear.	I	25	100
		S	25	100
Dep.	Shave me when I need to be shaved.	I	1	4
		S	5	20
Ind.	Let me decide when I need a shave.	I	24	96
		S	23	92

* Type Ind. Independent nursing care statement.
Dep. Dependent nursing care statement.

**Group S Secure Group.
I Insecure Group.

TABLE I (CONTINUED)

PATIENTS' REPORTED PREFERENCES FOR NURSING CARE STATEMENTS

Type*	Nursing Care Statements	Group**	"Yes" Responses To Statement	
	When people are taking care of me I wish they would:		Number	Percent
Dep.	Help me run my bath water so as to have the right temperature.	I	1	4
		S	5	20
Ind.	Trust me to run bath water at the right temperature.	I	22	88
		S	24	96
Dep.	Give me a bath when I need it.	I	2	8
		S	1	4
Dep.	Assist me in taking a bath.	I	3	12
		S	3	12
Ind.	Allow me to take my own bath.	I	25	100
		S	24	96
Ind.	Let me take care of my own hair.	I	25	100
		S	22	88
Dep.	Keep my hair combed and looking nice.	I	7	28
		S	6	24
Dep.	Help me become acquainted with others.	I	18	72
		S	23	92
Ind.	Allow me to become acquainted with whom I please.	I	25	100
		S	25	100
Ind.	Stay away when I am with a group of friends.	I	13	52
		S	10	40

* Type Ind. Independent nursing care statement.
Dep. Dependent nursing care statement.

**Group S Secure Group.
I Insecure Group.

Out of the thirty dependent items, the seven listed on Table II, were the only ones for which the insecure group showed a greater number of persons preferring the care than the secure group.

TABLE II

DEPENDENT NURSING CARE ITEMS FOR WHICH A GREATER NUMBER OF INSECURE PATIENTS INDICATED A PREFERENCE THAN THE SECURE GROUP

When people are taking care of me, I wish they would:
1. Keep sharp knives and instruments away from me.
2. Cut up my food and help me eat.
3. Be concerned about keeping me properly dressed.
4. Give me a bath when I need it.
5. Keep my hair combed and looking nice.
6. Defend me when others are angry with me.
7. See that my clothes are mended, cleaned and ironed.

The overall pattern of responses did not seem to be influenced by the patients' sex. There was nearly an equal number of patterns of answering occurring between the different combinations of these groups of patients: secure male, secure female; insecure male, secure female; insecure male, insecure female; and the insecure female, and secure male. On some items there was a marked difference between the secure male and insecure male groups, or between the secure female and insecure female groups, but these differences were cancelled by the exact opposite response occurring between the two groups of the other sex. Since, as noted before, these patterns varied and were about equal for all of the possible combinations nothing was done with these findings although they may have implications for future studies.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The purpose of the study was to find how preferences for certain kinds of nursing care, as reported by psychiatric patients, were related to the patients feelings of security and insecurity. The Security-Insecurity Inventory developed by A. H. Maslow and others, and a Nursing Care Preference Test developed by the researcher were administered to fifty patients from a state psychiatric hospital caring for 583 patients.

The Nursing Care Preference Test was developed to depict different methods of meeting a person's basic needs. The items were stated according to the manner in which an infant or young child would require having his needs met as opposed to how a normal well adult would require having the same needs met. The items depicted kinds of care that are offered in the psychiatric hospital and the kinds of care that it is generally accepted the very ill psychiatric patient would need.

The patients were divided into two groups for the purposes of this study. Those falling into the third and fourth quartiles of the range of scores obtained from Maslow's S-I Test were classified as being insecure. Those falling in the first and second quartiles were classified as being secure. The chi square test was used to test the significance of the relationship between the patients' reported security and his preference of the nursing care items.

An analysis of the data revealed a wide fluctuation in the patients reported preferences for the nursing care items. All but three of the fifty-one items differentiated to some degree between the patients' preferences for the kinds of nursing care depicted. However, as is noted in the analysis of the data chapter, the nursing care items did not differentiate to any significant degree between the preferences of those patients classified as secure and those classified as insecure. There was a slight indication that the secure person was able to report a preference for dependent nursing care more frequently than the insecure person. This trend was demonstrated in the one relationship that was found significant.

CONCLUSIONS

The findings of this study have very important implications because of the questions they raise. If the S-I Test is truly a measure of mental health, and the Nursing Care Preference Test represents kinds of care nurses give in attempting to improve the person's mental health, why was there no discernible relationship between these two tests? Was it because the patient's need for these basic kinds of nursing care is not

related to the degree of his mental illness? Is the care nurses give to patients really meeting the patients' needs as she thinks it is? There are some indications that what nurses think they are doing and what patients think nurses are doing are different. Also, can the S-I Test be taken as a complete measure of mental health or are there other factors not measured by this test that are factors in a person's mental health?

There are numerous theories that may be used in explaining the results of the study. Interpretations are to be used with caution due to the lack of sufficient evidence to validate them.

One explanation of the findings is that the items in the Nursing Care Preference Questionnaire did not differentiate between the secure and insecure patients' preferences for nursing care. A basic reason for this suggested failure may be that the Nursing Care Questionnaire was limited to the basic physiological needs and was not developed so as to include the patients need for belongingness and love.

To belong and be loved are very important needs in the development and maintenance of a person's security. It seems that in the mental hospital these needs might be the most important. When one level of a patient's needs have been satisfied, the amount of energy directed toward having these needs satisfied decreases. The satisfaction of the basic needs allows for the evolution of a new, and higher level of needs.[1] The mental hospital by its organization is structured to meet the first two levels of needs; those of the physiological requirements and safety. It is not organized to meet the third level of needs. It is reasonable to believe that in the hospital the third level of needs may arise and all of the person's capacities be directed toward obtaining belongingness and love, even to the point where nothing is more important to these people than to belong and be loved

The patients' sex should have some influence on the preference for nursing care because of the influence of culture on types of behavior that are or are not acceptable according to the persons sex. For example, "Put an arm around me when comforting me", has a sexual component because men usually do not receive this kind of attention when they are upset. Even though the responses from the different sexes cancelled out some of the wide varience between responses by members of the same sex, there was enough difference between the secure and insecure groups to show trends in spite of this sex cancellation. In another study more significant results might be obtained if this sexual factor were ruled out.

The responses may have been influenced by the patients' fear of indicating how ill he really was. This factor seems to be indicated by the larger standard deviation and the comments some of the patients made

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[1]A. H. Maslow, Motivation and Personality. (New York: Harper and Brothers Publishers, 1954). p. 42.

during the test. Some stated, "What are they trying to do, find out how crazy I am?" or others asked, "Will this keep me from going home?" Even though they were reassured, it is not possible to know how much these fears influenced the patients' responses to the test. This characteristic of the psychiatric patient in hiding his symptoms was noted by Caudill in his study of the social structure of the psychiatric hospital.[2]

A combination of factors seems to supply the best explanation of variables influencing the patients reported preferences for nursing care. These variables are: Conformity through the common consensus to social expectations of the hospital, acceptance of the role of a patient, giving socially and culturally acceptable responses and lack of knowledge on the part of the patients concerning how some types of nursing care would give them satisfaction.

Examination of Table I on page 24 shows that a majority of the dependent items for which most of the patients, regardless of their security score, reported a preference coincided with the type of care given in the hospital where the tests were conducted. Examples of this includes the high percentage of people stating a preference for the item "keep me in clean clothes." In the hospital studied all of the patients' clothes were taken to a central laundry, and there cleaned, mended, and ironed. This was a socially acceptable form of dependent behavior accorded to all patients in the hospital. All of the dependent items relating to this service of the hospital received fairly high percentages of patients accepting this care. The percentages of patients preferring each different type of dependent care decreased with its decrease in social acceptance. Probably in order to belong and be loved, the patients usually assume the "role" of a patient and conform to current practices and accepted stereotypes. The dependent types of nursing care that none of the patients were receiving at the time of the study, such as being fed, bathed, etc., had the lowest responses of preferences from these patients. These types of care were also the type of care that the most seriously ill patients require.

It is interesting to note, and offers a possibility for further research, that even though the insecure group usually refused the dependent types of care, the number of their preferences exceeded the secure groups' preferences for the most dependent types of nursing care planned for meeting basic needs. (See Table II, page 28.) These findings did not reach statistical significance but with further research may show that these insecure people do not trust others enough to be dependent on them in such ways as relying on them for decisions about how to spend money. The basic kinds of care when given usually show real acceptance from the person supplying such care.

These findings have implications for nursing care because caring for the insecure person in these basic ways may be the most favorable

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[2]William Caudill, The Psychiatric Hospital as a Small Society. (Cambridge-Harvard University Press, 1958). p. 114.

method of developing his trust in others. To bathe, to feed, to protect and care about a person is the most elemental, non-judgmental, and accepting kind of care the nurse can give.

Socially acceptable behavior also implies the need for belongingness and love. An example of this is where one hundred percent of the patients reported they would like to be allowed to clean up their own mess. People are trained from childhood to make certain responses in given situations because these are acceptable to the culture in which they are raised. Not all of these social graces leave a person when that person becomes mentally ill.

This study did not reveal if there was a lack of knowledge on the part of the patients concerning the kind of nursing care they might have found satisfying, but this may have been a factor influencing their responses. A person does not know if an experience would be satisfying if he has never had the experience. It is generally the belief that often these patients do not know, or are afraid of the kind of care that would help them become better.

Stanton and Schwartz report: "Staff members can and occasionally do, succeed in finding and meeting needs that the patient is unaware of, or that for one reason or another he cannot take the initiative in making known."[3]

All people have certain basic needs that have been met in some way or they would not be alive. The problem facing nurses is whether needs can be satisfied more effectively by certain kinds of nursing care than by other kinds. This matter is tinged strongly with value judgments. The findings should be generalized only to our culture. The effectiveness of one type of care over another would best be evaluated by measuring the increased growth of the person's mental health as this is judged in our culture.

Questions Raised by the Study. The preceding findings gave rise to the following questions: If psychiatric patients were offered greater opportunities of becoming dependent, would more of them become dependent? What interpersonal factors would be necessary for them to become dependent? Is allowing the patient to become dependent a means of helping him develop security, or would nursing care that offers the patient a greater opportunity to become independent help him develop feelings of security? What other types of nursing care are more or less helpful to a person in the development of security?

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[3]A. H. Stanton and M. S. Schwartz, The Mental Hospital. (New York: Basic Books Inc., 1954). p. 76.

RECOMMENDATIONS

On the basis of the findings of this study, several recommendations can be made:

1. A more precise tool for measuring patient preferences for nursing care should be developed: One that is related to the measurement of nursing care that increases the patients' feelings of belongingness, love, self-respect, and self-esteem should be the most valuable.

2. The S-I Inventory has to be evaluated for its effectiveness with the psychiatric patient and norms for the group developed.

3. One who is planning to do research using a questionnaire that might be threatening to patients should have the opportunity in advance to establish a relationship with the patients so as to enable the patients to develop some degree of trust in the researcher.

4. There is a great need for research in the area of the nurse-patient interactions. In order to study these interactions, it would be necessary to arrange carefully planned studies. Several different approaches to the patient through nursing care should be tried in different settings.

According to Maslow, for a person's needs to be determined, ". . .it is necessary to set up special conditions that foster expression of these needs and capacities that encourage and make them possible."[4]

It would be necessary that there be different groups of patients so that the feelings toward, acceptance of, and results of the nursing care in the different settings could be evaluated in comparison to other kinds of nursing care offered in other settings.

5. These studies would entail the development of several tools aimed at making more objective the observation of human behavior, the kinds of nursing care given, and the feelings patients have toward receiving this care.

This study gave some indications that the person's desire to be accepted in the hospital environment, his tendency to prefer familiar care and conformity may have been related to the nursing care preferences reported by the patients. More study is needed to show if the patients' desires to conform and be accepted by the hospital population are related to his need for security.

If, as John Dewey claims, "the very existence and definition of a

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[4]A. H. Maslow, Motivation and Personality. (New York: Harper and Brothers Publishers, 1954). p. 349.

need depends on the cognition of reality, of the possibility of gratification,"[5] perhaps the psychiatric hospital by its enforced dependence of the patient is helping him "develop needs" that he cannot have met in the outside society.

Many psychiatric patients may find a type of security in the enforced dependence of the hospital. How beneficial is this form of security when it is noted that many patients can make an adequate hospital adjustment but fail in all attempts to return to society? We return again to the question of what are the patients' needs and how can the hospital personnel help the patients learn to satisfy these needs so as to enable them to become productive persons in society again.

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[5]Maslow, op. cit., p. 151.

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APPENDIX

APPENDIX A

DEFINITION OF SECURITY-INSECURITY

TABLE

Insecurity	Security
1. Feeling of rejection, of being unloved, or being treated coldly and without affection, or being hated, of being despised.	1. Feeling of being liked or loved, of acceptance, or being looked upon with warmth.
2. Feelings of isolation, ostracism, aloneness or being out of it, feelings of "uniqueness."	2. Feelings of belonging, of being at home in the world, of having a place in the group.
3. Perception of other human beings as dangerous, threatening, dark, hostile or challenging: as a jungle in which every man's hand is against every other, in which one eats or is eaten.	3. Perception of the world and life as pleasant, warm, friendly, or benevolent, in which all, intend to be brothers.
4. Perception of other human beings as essentially bad, evil, or selfish: as dangerous, threatening, hostile or challenging.	4. Perception of other human beings as essentially good, pleasant, warm, friendly or benevolent.
5. Constant feelings of threat and danger: anxiety.	5. Feelings of safety: rare feelings of threat and danger: unanxious.
6. Feelings of mistrust; of envy or jealousy toward others; much hostility, prejudices, hatred.	6. Feelings of friendliness and trust in others; little hostility; tolerance of others; easy affection for others.
7. Tendency to expect the worst; general pessimism.	7. Tendency to expect good to happen; general optimism.
8. Tendency to be unhappy or discontented.	8. Tendency to be happy or content.
9. Feelings of tension, strain or consequences of tension, e.g., "nervousness," fatigue, irritability, nervous stomach and other psychosomatic disturbances; nightmares; emotional instability vacillation, uncertainty, and inconsistency.	9. Feelings of calm, easy and relaxation. Unconflicted. Emotional stability.
10. Tendency to compulsive introspectiveness, morbid self-examination, acute consciousness of self.	10. Tendency to outgoingness. Ability to be world, object, or problem centered rather than self- or ego-centered.
11. Guilt and shame feelings, sin feelings, feelings of self-condemnation, suicidal tendencies, discouragement.	11. Self-acceptance, tolerance of self, acceptance of the impulses.

12.	Disturbances of various aspects of the self-esteem complex, e.g., craving for power and for status, compulsive ambition, over-aggression, hunger for money, prestige, glory, possessiveness, jealousy of jurisdiction and prerogative, over-competitiveness; and/or the opposite; masochistic tendencies, over-dependence, inferiority feelings, feelings of weakness and helplessness.	12.	Desire for strength or adequacy with respect to problems rather than for power over other people. Firm, positive, well-based self-esteem. Feeling of strength. Courage.
13.	Continual striving for and hunger for safety and security, various neurotic trends, inhibitions, defensiveness, escape trends, ameliorative trends, false goals, fixations on partial goals. Psychotic tendencies, delusions, hallucinations, etc.	13.	Relative lack of neurotic or psychotic tendencies. Realistic coping systems.
14.	Selfish, egocentric, individualistic trends.	14.	"Social interest" (in Adlerian sense); cooperativeness, kindliness, interest in others, sympathy.[1]

[1]A. H. Maslow, Elisa Hirsh, Marcella Stein and Irma Honigan, "A Clinically Derived Test for Measuring Psychological Security-Insecurity," The Journal of General Psychology, 33:21-22, 1945.

APPENDIX B

NURSING CARE PREFERENCE TEST

Direction: Indicate how you would prefer to be cared for here in the hospital.

Circle YES if you prefer the care stated.
Circle NO if you do not prefer the care stated.

WHEN PEOPLE ARE TAKING CARE OF ME I WISH THEY WOULD:

NO YES 1. Stop me from becoming angry.

NO YES 2. Ask about and show an interest in the things I am doing.

NO YES 3. Not give me any responsibility.

NO YES 4. Let me decide who can or cannot take my belongings.

NO YES 5. Keep me in clean clothes.

NO YES 6. Allow me to plan my day's activities.

NO YES 7. Help me run my bath water so as to have the right temperature.

NO YES 8. Shave me when I need to be shaved.

NO YES 9. Make certain I get to bed on time.

NO YES 10. Provide warm covers and let me use them if I please.

NO YES 11. Let me take care of my own hair.

NO YES 12. Help me become acquainted with others.

NO YES 13. Select the things I should wear.

NO YES 14. Keep sharp knives and instruments away from me.

NO YES 15. Defend me when others are angry with me.

NO YES 16. Not worry about how much I eat.

NO YES 17. Avoid telling me what to make in O.T.

NO YES 18. Prevent others from doing the job that was assigned to me.

WHEN PEOPLE ARE TAKING CARE OF ME I WISH THEY WOULD:

NO YES 19. Put an arm around me when comforting me.

NO YES 20. Let me take care of my own clothing.

NO YES 21. Leave my food alone and let me feed myself.

NO YES 22. Advise me on how to spend my money.

NO YES 23. Avoid interfering when someone else is angry with me.

NO YES 24. Let me decide when I need a shave.

NO YES 25. Cut up my food and help me eat.

NO YES 26. Allow me to become acquainted with whom I please.

NO YES 27. Give me a bath when I need it.

NO YES 28. Help me decide what to make in OT.

NO YES 29. Let me report when I am constipated.

NO YES 30. Stay with me when I am using sharp knives and instruments.

NO YES 31. Check during the night to see that I am covered and warm.

NO YES 32. Trust me to run bath water at the right temperature.

NO YES 33. Allow me to manage my own money.

NO YES 34. Prevent patients from taking what belongs to me.

NO YES 35. Provide equipment so I can keep my clothes mended and ironed.

NO YES 36. Watch me so that I do not become constipated.

NO YES 37. Allow me to choose what I want to wear.

NO YES 38. Assist me in taking a bath.

NO YES 39. Let me assume job responsibility without others interference.

NO YES 40. Keep my hair combed and looking nice.

NO YES 41. Give me the opportunity to clean up my own mess.

NO YES 42. Be with me to help me dress.

NO YES 43. Keep my clothes in neat order.

WHEN PEOPLE ARE TAKING CARE OF ME I WISH THEY WOULD:

NO YES 44. Tell me what to make in O.T.

NO YES 45. Teach me not to become angry.

NO YES 46. Permit me to decide when I should go to bed.

NO YES 47. Stay away when I am with a group of friends.

NO YES 48. Be concerned about keeping me properly dressed.

NO YES 49. Allow me to take my own bath.

NO YES 50. Clean up my mess.

NO YES 51. See that my clothes are mended, cleaned, and ironed.

APPENDIX C

LETTER SENT TO SEVEN CONSULTANTS

Dear _____:

You were recommended to me as being an expert practitioner in psychiatric nursing and I am writing to ask if you would assist me with a thesis project by filling in the enclosed questionnaire.

I am a graduate student in psychiatric nursing at the University of Utah working on a thesis project. The questionnaire is my own and will be used with Maslow's Security-Insecurity Test to find if there is a relationship between the psychiatric patient's indicated security and his preference of nursing care.

This tool was developed on the basis of personality growth and development. The nursing care statements were categorized in two ways. They were stated so as to allow the individual answering the questionnaire to be able to select responses indicating dependence or independence. Both the independent and dependent statements were based on areas of basic needs present during growth and development. Some areas included are those of eating, sleeping, protection from self and the environment, and the needs that must be met for the development of self-worth or self-esteem.

To verify my selection and categorization of nursing care I am asking you and six other nurses who are expert practitioners in psychiatric nursing to mark each statement as indicating dependence or independence. Your answers will assist in determining the validity of the items.

I feel this study is important for the promise it offers of helping to improve our understanding and our nursing care of psychiatric patients.

I shall appreciate it very much if you will participate in the study and return the completed questionnaire in the enclosed self-addressed envelope. I should like to receive the questionnaire by Tuesday, February 20, 1962, if at all possible. I am aware that this is pressing you and does not allow much time. If you are unable to participate, would you please return the questionnaire?

Thank you for your willingness to help and for any comments you may add to the questionnaire.

Sincerely,

Enc.

APPENDIX D

INSTRUCTIONS TO CONSULTANTS ON CLASSIFICATIONS OF THE KINDS OF NURSING CARE

Directions:

Please read each statement carefully; then categorize it as "D"; "I"; or "X". Place the indicated response in the blank space to the left of the item.

Use "D" to indicate that kind of care that shows that the person is controlled, supported, or aided by others. (Dependent)

Use "I" to indicate the kind of care that shows that the person is free from the support or control of others. (Independent)

Use "X" to indicate any statement you find difficult to answer either "D" or "I". If you have additional comments to make or questions, please feel free to add them.